# Will Community Health Centers Survive COVID-19?

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## Community Health Centers Are Essential Providers of Health Care in Rural Communities

Federally qualified community health centers (CHCs) are the nation's primary care safety net, serving a patient population of whom 68% have incomes below the poverty level, 63% identify as racial/ethnic minorities, and 82% are uninsured or publicly insured.[1] Today, nearly 1,400 CHCs operate some 13,000 healthcare delivery sites nationwide,[2] providing high-quality, cost-effective, and comprehensive primary care (often including dental and behavioral health) to all regardless of ability to pay. CHCs also provide other health and social care services including pharmacy, nutrition, care management, health education, transportation, eligibility assistance, interpretation, and community outreach.

CHCs are critical to our nation's ability to respond to COVID-19 in rural and underserved communities, which are experiencing a rapid increase in cases. As of May 11, 2020, there are 85,748 cases and 3,298 deaths from COVID-19 in nonmetropolitan counties in the United States, representing 6.4% of cases and 4.2% of deaths nationwide.[3] Rural residents are at increased risk of poor outcomes due to age and health status, and there are substantially fewer healthcare resources available in rural areas, meaning that once the virus becomes more widespread in these communities, the results could be disastrous.[4]

Throughout their 55-year history, CHCs have survived social and political challenges despite limited resources. Once sustained almost entirely by grant funding, they now rely heavily on revenue from third-party payers, and most CHCs constantly struggle to meet the overwhelming demands of their mission while operating with razor-thin margins. The reality is even more grim in nonexpansion states where there has been no influx of Medicaid dollars to offset previously uncompensated care.

Unfortunately, the current COVID-19 pandemic has exacerbated the financial vulnerability CHCs face. As shown in Table 1, survey data collected by the Health Resources and Services Administration (HRSA) indicate that most—but not all—CHCs can provide COVID-19 testing, but nearly 15% of delivery sites are closed and over 10% of staff cannot work. Patient visits have declined by more than half compared to pre-COVID-19 levels, and more than half of remaining visits are being conducted virtually.[5]

## COVID-19 Poses a Serious Threat to CHCs Nationwide

Data from the National Association of Community Health Centers (NACHC) suggest many CHCs are experiencing dramatic decreases in net revenue—between 70% and

**Table 1** CHC COVID-19 Survey Data

| | April 3, 2020 | April 10, 2020 | April 17, 2020 | May 1, 2020 |
|---|---|---|---|---|
| CHCs w/ COVID-19 Testing Capacity | 80.1% | 82.2% | 85.0% | 87.9% |
| CHCs w/ Drive-Up/Walk-Up COVID-19 Testing Capacity | 38.0% | 44.2% | 48.0% | 65.4% |
| Patients tested for COVID-19 | – | 56,440 | 58,362 | 101,401 |
| Patients testing positive for COVID-19 | – | 9,292 | 8,886 | 19,956 |
| Weekly visits compared to Pre-COVID average | 54.3% | 47.3% | 51.2% | 55.6% |
| CHC Sites Temporarily Closed | 1,643 | 2,073 | 1,904 | 1,810 |
| CHC Staff Unable to Work | 16.3% | 14.4% | 14.0% | 11.9% |
| CHC Staff Tested Positive for COVID-19 | – | 1,381 | 707 | 509 |
| Avg. % of CHC Visits Conducted Virtually | – | 51.5% | 52.8% | 53.4% |
| % of CHCs w/ adequate PPE for next 7 days, by type | | | | |
| Surgical masks | 75.6% | 81.4% | 90.8% | 92.6% |
| N95 masks | 69.7% | 75.7% | 88.4% | 90.8% |
| Gowns | 67.4% | 72.4% | 86.6% | 86.7% |
| Gloves | 89.2% | 90.6% | 95.6% | 97.0% |
| Face masks/goggles | 70.3% | 75.1% | 89.2% | 93.0% |
| | N = 858 (62% of all CHCs) | N = 1,154 (83% of all CHCs) | N = 1,032 (74% of all CHCs) | N = 966 (70% of all CHCs) |

Source: HRSA, Health Center COVID-19 Survey, National Summary Report. https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data (site updated regularly, last accessed May 11, 2020).

Note: Data for each reporting date are not directly comparable, because different CHCs may be represented based on participation for that reporting period. Data not reported on April 24, 2020.

80%—as patients stop coming to CHCs because of stay-at-home orders and fears of COVID-19 exposure. The CHC workforce is also being reduced because of COVID-19 exposure/infection and the use of CHC staff as relief for hospital staff stretched thin. Meanwhile, CHCs' COVID-19-related expenses have increased for personal protective equipment (PPE), medical tents, testing supplies, and increased sanitation efforts. Amidst declining revenues and increasing costs, CHCs are closing delivery sites and/or furloughing staff.[6] NACHC projects that over the next 6 months, CHCs will lose $7.6 billion in revenue and be forced to eliminate over 100,000 jobs.[7]

COVID-19 is also accelerating CHCs' adoption of telehealth, as payers revise policies to classify CHCs as distant site providers and increase telehealth reimbursement during the crisis. This may improve healthcare access in rural areas, but it also strains CHCs' already precarious financial solvency as they invest significant resources in infrastructure.[8] Simultaneously, many rural residents lack high-speed Internet connections, and many lower income and older adults may lack web cameras, technological know-how, or a monthly Internet subscription. Most of these challenges can be overcome using telephonic visits, but—notwithstanding a new rule from the Centers for Medicare & Medicaid Services (CMS) that increases reimbursement for these visits[9]—many insurers refuse to pay for them, meaning CHCs often lose money each time they pick up the phone to care for a patient.[10]

## Current Efforts to Support CHCs May Not Be Enough to Save Them

The federal government has taken action to help CHCs at this critical time. First, Congress has provided funds to partially offset the reduced revenue and increased expenses CHCs are experiencing. Under the *Coronavirus Preparedness and Response Supplemental Appropriations Act*, HRSA provided $100 million in funding to 1,381 CHCs on March 24 to increase COVID-19 screening and testing capacity, rapidly expand telehealth capabilities, and purchase PPE to ensure workforce safety.[2] Just 2 weeks later, HRSA provided over $1.3 billion to 1,387 CHCs using *Coronavirus Aid, Relief and Economic Security (CARES) Act* funding to "help communities across the country detect coronavirus; prevent, diagnose, and treat COVID-19; and maintain or increase health capacity and staffing levels to address this public health emergency."[11] Then, on May 7, HRSA provided another $583 million to 1,385 CHCs to expand COVID-19 testing capacity using *Paycheck Protection Program and Health Care Enhancement Act* funds.[12]

Other *CARES Act* funding may also help CHCs,[13] including opportunities to increase telehealth capacity under the COVID-19 Telehealth Program and the Connected Care Pilot Program, which both received $200 million,[14] and the Paycheck Protection Program (PPP), which offers potentially forgivable loans to help small businesses meet payroll and avoid layoffs. Based on language in the *CARES Act*, CHCs should be given priority for PPP loans because

they are located in "underserved and rural markets" and their patient majority governing boards mean they are "owned and controlled by socially and economically disadvantaged individuals."[15] Ironically, some of the nation's largest and most successful CHCs may be hardest hit, because they have more than 500 employees and are ineligible for the PPP. Although just 6.5% of CHCs fall into this category, they employ 31% of CHC staff and treat 28% of CHC patients nationally.[13]

HRSA and CMS have used their regulatory capacity to relax policies in ways that will help CHCs function more effectively during the crisis. HRSA is allowing CHCs to temporarily suspend services at delivery sites, change the scope of services provided, offer COVID-19 screening and triage at off-site locations, and alter operating hours without seeking formal approval.[16] Similarly, using Section 1135 Waiver authority, CMS is relaxing CHC staffing requirements to increase flexibility, recognizing that CHCs may experience staffing shortages due to COVID-19.[17]

## Following COVID-19, CHCs Will Be Needed More Than Ever Before

The pandemic's effects will be felt long into the future, both as new cases are detected and as health outcomes deteriorate for patients who have delayed care for urgent and chronic conditions. We are just beginning to see the significant effects that the crisis is having and will continue to have on behavioral health, with a marked rise in depression and anxiety.[18,19] By providing integrated primary care and behavioral health services, CHCs will continue to serve an invaluable role in addressing these healthcare needs, reducing emergency department visits and potentially avoidable admissions, thereby easing the burden on already strained hospital systems.

The debate over what our "new normal" will look like is far from settled, but one thing is certain: we will need a robust primary care safety net just as much as, if not more than, we always have. Public health efforts to combat COVID-19, while effective, have also drastically reduced economic activity. The prospect of a serious recession or depression is very real. We have already witnessed a record number of individuals filing for unemployment benefits, and the economy may or may not quickly recover once social distancing policies are loosened. People will lose their health insurance coverage along with their jobs. In some cases, people will newly qualify for Medicaid or Marketplace coverage; in others, people will simply become uninsured. Either way, demand for CHC services will increase.[8]

To bolster the program, NACHC is petitioning Congress for $77.3 billion in CHC funding. This includes $7.6 billion to offset revenue lost due to COVID-19, $7.8 billion over 5 years to expand workforce programs like the National Health Service Corps, teaching health centers program, and Nurse Corps Loan Repayment Program, $41.9 billion over 5 years to stabilize existing services and prepare for the influx of 10 million new patients expected from the economic downturn and population growth, and $20 billion over 5 years to fund infrastructure investment, which last occurred in 2009.[20] This level of funding for CHCs would be historic. Yet, it is vital.

Rural communities will benefit greatly from the rapid expansion of telehealth capacity at CHCs in response to COVID-19 if payers sustain the increase in telehealth reimbursement after pandemic. Still, there remains a crucial need for skilled providers—physicians, nurse practitioners, physician assistants, dentists, behavioral health providers, pharmacists, and nurses—to serve America's rural populations. CHCs are well positioned to provide that care, but their future is now threatened by the COVID-19 pandemic. We must invest in CHCs now or risk many of them closing. Allowing the COVID-19 pandemic to lead to a reduction in primary care, dental, and behavioral health capacity in rural areas with an already limited supply of providers would prove catastrophic.

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